DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11028 (Rev. 06/03)

STATE OF WISCONSIN
HFS 107.06(2), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPECIALIZED MEDICAL VEHICLE ATTACHMENT (PA/SMVA)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

Attach the completed Prior Authorization/Specialized Medicaid Vehicle Attachment (PA/SMVA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary, and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

SECTION I — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)	Age — Recipient

Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

Name — Performing Provider	Telephone Number — Performing Provider

Performing Provider's Medicaid Provider Number

A. Do you have a current Physician Certification, signed by a physician, physician assistant, nurse midwife, or nurse practitioner documenting the recipient's need for specialized medical vehicle (SMV) transportation on file for this recipient?

❑ Yes ❑ No

B. Attach a copy of the prescription for trips that exceed the SMV mileage limit signed and dated by a physician, physician assistant, nurse midwife, nurse practitioner, dentist, optometrist/optician, chiropractor, podiatrist, HealthCheck agency, or family planning clinic.

SIGNATURE — Requesting Provider	Date Signed

Reset Form